STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

APPLICATION FOR A DISABILITY ALLOWANCE

Under **The Americans with Disability Act,** an employer is obligated to provide reasonable accommodation to enable a person with a disability to perform essential functions of the job and to enable an employee with a disability to enjoy benefits and privileges of employment equal to those enjoyed by non-disabled employees.

ELIGIBILITY REQUIREMENTS

- You cannot perform the duties of your assigned job, due to a physical or mental impairment.
- You have ACTIVE status with your last employing Connecticut board of education.
- You have five years of credited service in the public schools of Connecticut, unless the disability is service related.
- You do not qualify for normal benefits. (35 years service or 20 years of CT service at age 60).

"Disabled" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long continued and indefinite duration, except that during the first twenty-four months that a member is receiving a disability allowance, "disabled" means the inability to perform the usual duties of his/her occupation by reason of any such impairment.

FILING REQUIREMENTS

All six (6) items must be received by this office PRIOR to the effective date of your benefit.

1. Application for a Disability Allowance including your 1%/Voluntary Account Payment Election.
2. Beneficiary Designation Form.
3. Birth Certificate (Photocopy).
4. Handwritten statement from you outlining the effect your illness has on your ability to perform your job duties and your day to day personal activities.

Also,

5. Your doctor(s) must submit a written statement declaring that you are disabled and unable to perform your duties as an educator. Copies of medical reports, tests, evaluations, diagnosis, and method of treatment must also be submitted. The authorization form you give your doctor to release this information to us is enclosed.
6. Your principal and/or your supervisor must submit a report or statement providing background of your status, which may include days missed from school, difficulties at work, additional assistance required to do your job, etc. The request form to provide to your principal/supervisor is enclosed.

LATE FILING RESULTS IN LOST BENEFITS

CTRB DISABILITY REVIEW PROCESS

Our Medical Review Committee (panel of licensed private doctors) reviews the medical evidence and required statements. They forward a recommendation to the Teachers' Retirement Board. The Committee meets on the first Tuesday of every month (excluding August). All items to be reviewed must be received by this office no later than the 18th of the month prior to the meeting date. When the 18th of the month falls on a weekend or State holiday, the deadline becomes the first business day following the 18th. After the MRC meeting, you will receive written notification of the results of the meeting, and if approved, an Effective Date Election Form for your immediate completion.

The disability income will cease when the disability ends. The Board may call upon the member to submit periodic medical reports, and determine that a member's disability has ended if it finds that the member has failed to pursue an appropriate program of treatment.

Disability benefits will be calculated at 2% of your final salary base (average of highest three paid salaries) times the years of full-time credited service, subject to a maximum benefit of 50% of final average salary, and minimum benefit of 15% of final average salary (for 7.5 or fewer years of service).

1%/VOLUNTARY ACCOUNT PAYMENT ELECTION

Members who were employed prior to June 1989 have a 1% account. Members who paid additional monies into the system have a Voluntary Account. You must make an election as to how you would like the account(s) distributed.

The following choices are available:

(1) Lump Sum: A refund of your account balances will be issued approximately 60 days after your effective date of disability. The interest portion is taxable unless rolled over into an IRA or another Qualified Plan. Additional information will be sent to you regarding the distribution of the account(s) if you select this option.

(2) Monthly Annuity: In lieu of receiving your 1% and/or Voluntary account in a lump sum, you may elect to increase your monthly payment with an additional fixed annuity based on your account balance and age annuity rates in effect at the time of your disability effective date.

OFFSETS AGAINST INCOME WHILE COLLECTING A DISABILITY ALLOWANCE

During the first twenty-four months, twenty percent of any earned income or wages shall be subtracted from the disability allowance payable unless the Board determines that such earned income is being paid as part of the rehabilitation of the member.

After the first twenty-four months, your disability allowance and your earned income can equal the "final average salary" we used to compute your disability allowance. All earnings in excess of this amount are subtracted from your disability allowance.

A dollar for dollar offset will apply if the total of the disability allowance, less cost of living adjustments plus any initial award of social security benefits or worker's compensation, exceeds seventy-five percent of the member's final average salary.

CONVERSION OF BENEFIT

Service credit will accrue to a maximum of 30 years while receiving disability allowance. Upon the attainment of age 60 (or older) with a minimum of 20 years of CT credited service (including accrued service), the disability allowance will be converted to a normal retirement benefit. You will be required to select a payment plan and your converted benefit will include any cost of living adjustments accrued while on disability.

For CTRB use only

Effective Date: _____

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

APPLICATION FOR A DISABILITY ALLOWANCE

I am applying for disability due to: _____

The nature of my disability (circle one): Physical Psychological Physical/Psychological

_____
Name of Applicant Date of Birth Social Security Number

_____
Street Address

_____
City State Zip Home Phone # Email Address

1% and Voluntary Account Payment Election (check one option per account type):

Account Type	Lump Sum*	Monthly Annuity
1% Account	☐	☐
Voluntary Account	☐	☐

***** If you elect the lump sum option, additional information will be sent to you regarding the distribution of the account(s).

****

Your Disability Application must be complete before it may be submitted to the Medical Review Committee for evaluation, including:

1. Application for Disability Allowance including the 1%/Voluntary Election
2. Beneficiary Designation Form
3. Birth Certificate (Photocopy)
4. Handwritten Personal Statement
5. Personal Physician's Reports
6. Principal/Supervisor Statement

Under current laws and regulations, Medical insurance is available with your last employing Board of Education until you are enrolled in Medicare A, at which time supplemental insurance is available through Teachers' Retirement.

Certification Statement:
I will report any earned income, Social Security and Worker's Compensation Benefits to the Teachers' Retirement Board and submit periodic medical reports when requested.

_____
Applicant's Signature **Date**

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

BENEFICIARY ELECTION FOR DISABILITY ALLOWANCE

Connecticut Statutes require that monthly survivor benefits be paid to your statutory survivors before any balance is paid to your designated beneficiary. This is true regardless of whom you designated as your beneficiary. Statutory survivors include a spouse and/or minor children under the age of 18. You should refer to our **Survivorship Benefits Before Retirement Bulletin** before completing this form. Contact this office if you need assistance.

- Type or print clearly in ink, initial any changes that you make, and do not use white out.
- You may name any living person, your estate, or a trust as your beneficiary.
- A trust designation must include the name and date of the trust agreement.
- At least one primary beneficiary must be named. If more than one primary beneficiary is named, the share of any beneficiary who dies before you shall be divided equally amount the surviving primary beneficiaries.
- A payment is made to a contingent beneficiary(ies) only if all primary beneficiaries die before you do.
- If you survive all of the beneficiaries named, payment would be issued to your estate.
- "Per Stirpes" designation (unnamed or unborn beneficiaries) is not accepted.

MEMBER NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	SOCIAL SECURITY NUMBER
STREET ADDRESS	LOCAL SCHOOL DISTRICT
CITY, STATE, ZIP	CHECK IF: NEW ADDRESS ☐ NAME CHANGE ☐

I, the undersigned, hereby direct the Connecticut Teachers' Retirement Board, in the event of my death prior to retirement, to pay the death benefit allowable on my account to the beneficiary or beneficiaries named below in accordance with Section 10-183h of the Connecticut General Statutes.

BENEFICIARY NAME (FIRST, MI, LAST)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH	(CHECK ONE) ☐ PRIMARY ☐ CONTINGENT
BENEFICIARY NAME (FIRST, MI, LAST)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH	(CHECK ONE) ☐ PRIMARY ☐ CONTINGENT
BENEFICIARY NAME (FIRST, MI, LAST)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH	(CHECK ONE) ☐ PRIMARY ☐ CONTINGENT
BENEFICIARY NAME (FIRST, MI, LAST)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH	(CHECK ONE) ☐ PRIMARY ☐ CONTINGENT
BENEFICIARY NAME (FIRST, MI, LAST)	RELATIONSHIP	SOCIAL SECURITY #	DATE OF BIRTH	(CHECK ONE) ☐ PRIMARY ☐ CONTINGENT

SIGNATURE OF MEMBER	DATE	WITNESS (OTHER THAN BENEFICIARY)	DATE

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

SURVIVORSHIP BENEFITS - SETTLEMENT INFORMATION

CTRB Disability Allowance recipient dies PRIOR to meeting retirement eligibility requirements:

Spouse?	Primary Beneficiary	Minor Children?	Settlement of Account
Yes	Spouse	Yes	Surviving Spouse Benefit and Minor Child Benefit
Yes	Other	No	Surviving Spouse Benefit
Yes	Spouse	No	Surviving Spouse Benefit or Lump Sum Payment
No	Children	Yes	Minor Child Benefit
No	Children	No	Lump Sum Payment to Beneficiary
No	Other	No	Lump Sum Payment to Beneficiary
No	Other	Yes	Minor Child Benefit

CTRB Disability Allowance recipient dies AFTER meeting retirement eligibility requirements:

Spouse?	Primary Beneficiary	Minor Children?	Settlement of Account
Yes	Spouse	Yes	Surviving Spouse Benefit or Lump Sum Payment or Plan D 100% Co-participant Benefit plus Minor Child Payment
Yes	Other	No	Surviving Spouse Benefit
Yes	Spouse	No	Surviving Spouse Benefit or Lump Sum Payment or Plan D 100% Co-participant Benefit
No	Children	Yes	Minor Child Benefit
No	Children	No	Lump Sum Payment to Beneficiary
No	Other	No	Lump Sum Payment to Beneficiary
No	Other	Yes	Minor Child Benefit

Retirement Eligibility Requirements:

- 10 years of CT credited service at age 60 or over.
- 20 years of credited service at age 55 (minimum 15 in CT).
- 25 years of credited service any age (minimum 20 in CT).

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

MEMBER PERSONAL STATEMENT FOR DISABILITY ALLOWANCE

You are required to submit a handwritten statement outlining the effect your illness has on your ability to perform your job duties and your day to day personal activities. Please be as specific as possible.

Date: _____

From: _____
Name of Applicant Social Security Number Employer

To: Connecticut Teachers' Retirement Board Medical Review Committee

I am applying for disability due to: _____

_____
Applicant's Signature **Date**

MEMBER'S PERSONAL STATEMENT:

You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

PERSONAL PHYSICIAN'S AUTHORIZATION FORM FOR DISABILITY ALLOWANCE

To be completed in ink (printed) by the applicant and given to his/her doctor.

Date: _____

To: _____, M.D.

From: _____ SSN _____

_____

_____

I am applying for disability due to: _____

I hereby authorize you, my attending physician, to provide the Teachers' Retirement Board Medical Review Committee (panel of licensed private doctors) all medical data necessary for a determination of my eligibility for benefits. Further, I understand that all expenses relative to examination or submission of such medical data by you will be paid solely by me and will not be reimbursable by the Teachers' Retirement Board.

As my attending physician, I am asking your cooperation in submitting a statement declaring that I am disabled and unable to perform my duties as an educator.

In addition, please forward the following information:

- Present Illness and Past History
- Tests , Reports, Evaluations
- Lab work
- X-ray and EKG reports
- Hospital summaries
- Prognosis and method of treatment
- Medications
- Multi-axial diagnosis and mental status examination (if psychological disability)

Thank you in advance for your cooperation in this matter.

_____

Applicant's Signature **Date**

TO THE DOCTOR: Please mail or fax your report directly to this office. Please do not write on the back of this form or on the back of any additional forms.

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

PERSONAL PHYSICIAN'S AUTHORIZATION FORM FOR DISABILITY ALLOWANCE DISABILITY BASED ON PSYCHIATRIC CONDITIONS

Date: _____

To: _____, M.D.

From: _____ SSN _____

_____

_____

I am applying for disability due to: _____

I hereby authorize you, my attending physician, to provide the Teachers' Retirement Board Medical Review Committee (panel of licensed private doctors) all medical data necessary for a determination of my eligibility for benefits. Further, I understand that all expenses relative to examination or submission of such medical data by you will be paid solely by me and will not be reimbursable by the Teachers' Retirement Board.

As my attending physician, I am asking your cooperation in forwarding a statement declaring that I am disabled and unable to perform my duties as an educator.

In addition, the psychiatric report submitted should include the following information:

1) Present illness
2) Past history
3) Mental status examination
4) Multi-axial diagnosis
5) Medications, treatment plan and prognosis

Thank you in advance for your cooperation in this matter.

_____

Applicant's Signature **Date**

TO THE DOCTOR:
Please mail or fax your report directly to this office. Please do not write on the back of this form or on the back of any additional forms.

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

PRINCIPAL/SUPERVISOR STATEMENT FOR DISABILITY ALLOWANCE

Date: _____

From: _____
Name of Applicant Social Security Number Employer

To: _____
Name of Principal or Supervisor Title

I am applying to the Connecticut Teachers' Retirement Board for Disability. I authorize you to submit a statement to Connecticut Teachers' Retirement Board. This statement should include background information such as days missed from school, difficulties I have had at work, additional assistance I have required, etc.

_____
Applicant's Signature **Date**

STATEMENT OF PRINCIPAL/SUPERVISOR:

_____
Signature of Principal/Supervisor **Title** **Date**

TO PRINCIPAL/SUPERVISOR:
Please complete this form and mail or FAX directly to this office. You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

FEDERAL AND CT TAX WITHHOLDING ELECTION FOR DISBILITY ALLOWANCE

Print Name | Social Security Number

Address | City | State | Zip

( ) | /01/

Home Phone | Email Address | Month Effective

FEDERAL TAX ELECTION

Please select one option below:

1. ☐ No withholding. I realize that I am liable for payment of Federal Income Tax on my CTRB Disability Allowance.

2. ☐ I wish to have $_____ withheld monthly for Federal Income Tax.

3. ☐ I would like to have the computer calculate the withholding based on the following status and exemptions:

   Circle One: Married Single Exemptions: _____
   (TRB will code zero exemptions if none is specified)

   Optional for choice 3: I wish to have $_____ withheld from my monthly Disability Allowance in addition to the withholding based on status and exemptions.

CONNECTICUT TAX ELECTION

CTRB can only withhold State taxes for the State of Connecticut. If you have any questions on your Connecticut tax obligation, contact the Department of Revenue at 1-800-382-9463 (in CT) or 1-860-297-5962 (in Hartford, CT) or visit their website @ www.ct.gov/drs.

1. ☐ I elect to have $_____ withheld monthly for Connecticut Income Tax.
   (Whole dollar amount only, percentages not acceptable)

2. ☐ I elect to have **NO** Connecticut income tax withheld from my CTRB Disability Allowance.

Applicant's Signature **Date**

YOU MAY CHANGE THIS ELECTION AT ANY TIME BY COMPLETING A FEDERAL/CT WITHHOLDING CHANGE FORM WITH THIS OFFICE.

STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

ELECTRONIC FUNDS DEPOSIT (EFT) AUTHORIZATION - (MANDATORY)

You are required to have your monthly benefit payments sent electronically to the financial institution of your choice. The financial institution must be a member of the National Automated Clearing House Association.

TO BE COMPLETED BY MEMBER:

I authorize the Connecticut Teachers' Retirement Board to initiate electronic deposit and if necessary, debit entries and adjustments for any deposit entries in error, to my account indicated below and the bank named below to credit and/or debit the same to such account. In the event of my death, I authorize my estate to reimburse CTRB for any amounts which I was not entitled to receive and which were deposited following my death.

Bank Account Type (select one): ☐ Checking ☐ Savings

Member's Name	
Street Address	SSN
City, State, Zip	Home Phone ( )
Member's Signature	Date Signed

TO BE COMPLETED BY FINANCIAL INSTITUTION:

Routing Transit Number (Not to exceed 9 digits)	Bank Account Number (Not to exceed 17 digits)

Financial Institution must be a participating member of the National Automated Clearing House Association (NACHA).

Name of Financial Institution	
Street Address	
City, State, Zip	Phone ( )
Signature of Representative	Date Signed